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ABSTRACT

The need for continuing education about human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) was assessed for health care workers in metropolitan South Australia. Seventeen focus group discussions were held to solicit the views and experiences of various persons regarding HIV/AIDS tertiary education. Included in the discussion groups were health care professionals involved in HIV/AIDS provision, HIV-positive persons, health and welfare service providers, policymakers, and advocacy groups. The participants generally agreed that health care workers need a both a workable knowledge about the medical science of HIV/AIDS treatment and insight knowledge of the human side of working and living with HIV/AIDS. The curriculum for HIV/AIDS tertiary education should be developed in consultation and collaboration with HIV-positive persons, and the goal of training should be to present an integrated approach to the management of treatment and care that focuses on both the person and the disease. (Information about HIV/AIDS training for health care and allied workers, summaries of the focus group discussions, a summary of the initial survey of current tertiary HIV/AIDS education programs for health care workers, and the matrix model used to classify data from the discussions are appended.) (MN)

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In the interpretive approach to research, which characterises the report, success is almost entirely dependent on the goodwill and co-operation of scores of people, providing their hard pressed time to reflect openly and searchingly about the nature of their complex roles and the many personal observations that comprise the rich source of our material. We have been most impressed and sometimes quite moved by the humanity and professionalism of the people who have helped us understand the deep nature of the research, which goes far beyond the collection of data for abstract generalisation and the raw material of policy formation and planning of services.

Without naming all the individuals personally please accept our sincere thanks to our many helpers and supporters. We feel moved though, to pay special thanks to Marilyn McCarthy and Rob Willoughby who were a constant source of enthusiasm and encouragement when, sometimes, the going got hard. We hope that our report is a fair reflection of all your contributions. All errors and misunderstandings are of our making alone.

This research project was a joint initiative between the South Australian Health Commission and the University of South Australia and was funded under the Commonwealth HIV/AIDS Study Grants Program.

Abstract

This study should be read and assessed as a contribution to the continuous process of curriculum development, reflecting the changes of knowledge and the skills of applied practice in HIV/AIDS health care provision. The next stage of this study in which we present and discuss our ideas on tertiary education curriculum for health care workers (HCWs) with program designers and providers should prove as interesting and formative as this one.

In conducting a series of focused group discussions, about the views and experiences of HCWs and other interested and involved parties in the complex field of HIV/AIDS health care provision, relevant to the development of a tertiary education curriculum for confident and competent practice, we came to the view that *ideally* it was important for all kinds of HCWs to have a workable knowledge about the **medical science**, that is, the verifiable, empiricist and positivist learning base of HIV/AIDS and **insight knowledge** of the human, affective and feeling side of working with and living with HIV/AIDS, which is likely to be learned on the basis of experience but is also sufficiently understood formally to comprise a key part of any curriculum for workers in the field or about to enter it as a practitioner. Hence the use of the term *Knowing Both* as the slightly mysterious title for the study. It expresses the idea, put to us on the many occasions we talked to people in the HIV/AIDS field, for a balanced learning agenda and *ideally* the basis of confident and competent best practice for quality care.

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Section One: Introduction

PURPOSE AND SCOPE OF THE RESEARCH PROJECT

The purpose of this short report is to present, in summary form, the views and experiences of various groupings below–

- health care professional workers in HIV/AIDS care provision
- some HIV positive people and others in the affected community
- health and welfare service providers, policy and advocacy groups
- and other commentators able to represent complementary interests and perspective's on the subject matter of HIV/AIDS

The specific purpose is to identify and record their thinking about what health care workers need to learn through tertiary education and training programs to acquire the knowledge and skills for confident and competent working in the HIV/AIDS field.

An important point to note at the beginning of this report is that the focus of the research changed to that expressed above, from a narrower one, that is, on the scale and nature of current HIV/AIDS education and training provision for health care workers (HCWs) in the South Australian tertiary education sector. Our preliminary survey produced too little data of a documentary kind to form any impressions of HIV/AIDS education and training programs, certainly not sufficient for any analysis and interpretation for curriculum development purposes. This fact only fully revealed itself once the research was just under way. At that juncture in the early development of the research design, the steering group quite sensibly advised a change of tack. Hence the refocussing upon the views of professional HCWs and others with insights to report about the health care and other forms of provision for people with HIV/AIDS, on the basis of their experiences and advice, about the most suitable forms of education and training for other HCWs needing a foundation of knowledge and skills for confident and competent practice.

The importance of this change of focus lies in the value of the data as a means of a discussion based approach to curriculum development with tertiary education staff having teaching and learning responsibilities in HIV/AIDS programs designed for HCWs in South Australian institutions. This process is intended for the second phrase of the entire action research project and will be reported in a subsequent study. It also demonstrates how important it is to

think of this rather exploratory research as open and flexible to an obvious need to refocus and head off in a different direction from the original intention. Action research should always be about adaptability and learning from experience

In that context the report should be regarded as a contribution to the continuous process of curriculum development undertaken by tertiary education program coordinators and teaching staff responsible for the design and delivery of HIV/AIDS education courses for a variety of health care workers; in this study ranging from new learners to those updating their knowledge and skills to complement practical experience, and at different levels of course provision from the basic to the most advanced postgraduate studies. The location of the research centres exclusively on the HIV/AIDS scene and tertiary education institutions in South Australia (SA), in the latter part of 1992 and early 1993.

LIMITATIONS ON THE SCOPE OF THE PROJECT

This needs assessment is confined to the HIV/AIDS scene in South Australia, as reported by a number of professional health care workers and other support services representatives who participated in the focus group discussions within the research brief, outlined above. The project is also almost entirely confined to the respondents views and experiences of practical work and involvement in the HIV/AIDS field, rather than a typical academic approach, which would rely heavily on an understanding of the extant literature as a background context to the field work. We were not required in the research design to explore the relevant literature, although we did make our own discoveries in following up some ideas and sources of knowledge when curiosity got the better of our research time lines. Nor did we expect the respondents to demonstrate their "book learning" knowledge of HIV/AIDS to support their views and experiences of the practical aspects of their work and involvement. We noted in our subsequent field work that no respondents dogmatically insisted that their experiential learning transcended other ways of knowing and understanding the complexities of HIV/AIDS, but rather they were contributing to the process of acquiring knowledge and learning from a valuable practical standpoint.

BACKGROUND PAPER FROM THE HIV/AIDS PROGRAMS UNIT

The importance of a background paper from the HIV/AIDS Programs Unit of the SA Health Commission should be noted in shaping the purpose and scope of

the research project (*Background paper 1*). In sum, the paper describes the background to the research project and its funding, largely based on the perceptions of the authors about the need for an independent study arising from their innovative work as educators taking knowledge of HIV/AIDS to a wide range of people. The paper quite astutely identifies the barely hidden agendas of learning about HIV/AIDS, which like no other disease of the late twentieth century, confronts people with the disturbing, and often fearful, related personal issues of the complexities of human sexuality; social and psychological deviance, moral judgements and discrimination; and slow death.

The paper argues for the need to continue to equip health care workers with education and training provision that both constructs a learning environment that accurately transmits the basic knowledge of HIV/AIDS as a viral disease but more significantly addresses and facilitates the exploration of these "meaning of life" type issues so that health care workers (and others) are able to relate to and help the HIV positive person in a constructive manner, without the baffles of their own fears and prejudices getting between their role responsibilities as an empowering carer. The paper points out that the SA tertiary education institutions were mostly left to their own devices in dealing with this deeper knowledge material in their HIV/AIDS program provision for health care workers and that not much is known about the nature of their thinking regarding these curriculum matters.

ASSUMPTIONS ABOUT THE CURRICULUM DEVELOPMENT PROCESS

We have taken it for granted that tertiary education staff in HIV/AIDS education and training programs, in SA as elsewhere, are anxious to learn from the views and experiences of those with close up practical knowledge and an overview perspective, as represented by the groupings generally referred to above, so that they can respond to such field based reflection and consider their relevance to existing curricula. One of the hallmarks of a flexible and open minded curriculum is the capacity to incorporate new thinking, often expressed as practical knowledge and applied skills, as it happens, before textbooks get written or other forms of written codification takes place.

Section Two: Research Methods

OUTLINES OF THE AIMS AND OBJECTIVES OF THE RESEARCH

As the following statement indicates, the original research aims and objectives were principally descriptive and intended to provide a means of comparison based on existing HIV/AIDS curriculum and programs in the SA tertiary institutions. In actual practice the views and experiences of the field based practitioners in HIV/AIDS health service provision drove the research first and foremost with the data from the tertiary education providers subsequently used to compare findings. The original aims and objectives are listed below, without further comment, except to note that we changed the name from HIV Disease to the more familiar HIV/AIDS, viz-

Original Aims of the research

- **To describe the nature and extent of the current provision of educational programs on HIV disease for health care workers (HCWs) in SA tertiary institutions (three universities and TAFE) from initial and preparatory professional development through to post training experience, and continuing vocational levels.**
- **To develop "ideal type" model curricula as the basis of professional development programs for HCWs appropriate to the need from confident and competent work with HIV disease in a variety of contextual settings, embracing both general knowledge and skills and relevant specialisation according to the needs of particular health care disciplines.**
- **To develop an action plan for future implementation in SA tertiary institutions for HCWs working with HIV disease.**

The actual research aims were changed to those listed at the beginning of the report, for the reason explained earlier on page one.

TWO KEY FEATURES OF THE RESEARCH DESIGN

Before presenting the key findings, drawn from a series of focus group discussions, it is necessary to describe the ways in which the research was designed, that is, from the identification of the sample of respondents for the focus group discussions, to the ways in which the search for data was framed and the results summarised. Before outlining these matters it should be noted that the research approach was decidedly ***interpretive*** and ***existential*** in spirit and form, as this was clearly most appropriate given the nature of the task and the timeline within a restricted budget.

In practice our strategy was to collect mostly qualitative data based on the views and experiences of the sample groups and to interpret their thinking as a number of thematic focal points that could be readily addressed as implications for the structure, content and process elements of the development of curricula for HIV/AIDS education programs for a variety of health care workers attending SA tertiary institutions.

Moreover, the approach to the research is also best described as an action learning one because the team needed to understand HIV/AIDS and health care practice and, above all, it was necessary to make adjustments to some aspects of the design as we proceeded, in addition to the change to the original purpose. This does not mean that we changed the sample or the content of the focus discussions but rather the way in which we were to set about the task of interpreting the data using three groups to assist us; the AIDS Council of SA, the HIV/AIDS Programs (formerly Education) Unit of SA Health Commission and the project steering/advisory group, which invariably involved some membership overlap. This approach really only suggested itself in the light of our experience in relating to some of the leading people in the HIV/AIDS field in South Australia.

IDENTIFYING THE SAMPLE

Advice was principally taken from the advisory/steering group members as to who they considered best represented the local field of knowledge, as it were, bringing together professional workers across the more applied and involved health care disciplines in the practice and provision of HIV/AIDS care in SA, and the various other people and community interests. This consultative process inevitably and rightly took time and sometimes occurred during the data gathering as it became clearer who had something of particular practical value to add to an understanding of views and experiences from the field. The type and number of consultations representing the actual sample are shown in Table 1.

THE VALUE OF THE *DACUM* PROCESS

Much of the sample formation process suggested itself as a consequence of a day long workshop representing a cross section of health care workers and tertiary educators in HIV/AIDS, intended to determine the kinds of knowledge and skill requirements for confident and competent health care work in the fields of practice and provision. The workshop was described as a DACUM

process, design-a-curriculum, and tapped into the thinking of a wide span of health care workers. A considerable amount of basic thinking was generated which definitely helped the research team better understand the scope and nature of the education needs for confident and competent health care work in HIV/AIDS.

Specifically the content of the focus group discussions was shaped by the ideas coming from the workshop, as will be shown shortly.

THE SAMPLE DEFINED

It was agreed that we should try to cover the views and experiences of a diverse range of groups for the focussed discussions, representing a broad span of professional practice, advocacy and policy information and wider aspects of the politics of health and related forms of provision, including those with HIV/AIDS, and other people contacts/community interests, identified in Table 1 below–

Table 1: Framework for Focused Group Discussions: South Australia Tertiary Education Needs Assessment for Health Care Workers in HIV/AIDS Service Provision and Practice

Tertiary Knowledge and Skills Disciplines Identified in Needs Assessment

Medicine	Dentistry	Nursing	Allied Health Services	Social Work	Counselling
Specific Focus on HIV/AIDS Education for the following Health Care Workers:					
• General Practitioners • Doctors in Gynaecology and Obstetrics • Doctors in Palliative Care • Specialised Doctors in STD	• Dentists	• General Nurses (Hospital and Home/ Community based) • Specialised Nurses in Infectious Diseases and Midwifery	• Radiographers and Physiotherapists	• Social Workers	• Counsellors
Focused Group Discussions with Health Care Workers in HIV/AIDS Service provision and Field Based Practice					
• General Practitioners • Doctors in Gynaecology and Obstetrics • Doctors in Palliative Care • Specialised Doctors in STD	• Dentists	• General Nurses (Hospital and Home/ Community based) • Specialised Nurses in Infectious Diseases and Midwifery	• Radiographers and Physiotherapists	• Social Workers	• Counsellors

Table 1 continued overleaf

Table 1 continued

Focused Group Discussions with HIV/AIDS Affected Community Groups

Gay and Lesbian Rights
Injecting drug users
People living with HIV/AIDS
Sex Industry Workers

Focused Discussions with HIV/AIDS Community Based Service Providers, Policy and Advocacy Groups

Aboriginal Community Recreation and Health Service
AIDS Council of South Australia
Catholic Diocese HIV/AIDS Service
Family Planning Association
Haemophilia Society

Correspondence with Official Bodies representing Professional Interests and Concerns on HIV/AIDS Matters

Australian Medical Association
Allied Health Associations
Australian Dental Association
Nurses Board of South Australia

THE FOCUS GROUP DISCUSSIONS

These were, as the name suggests, closer to an open ended discussion than a formal interview, especially as there was no schedule to follow with set questions but rather a format within which respondents were asked to express their views and experiences about HIV/AIDS in general and what they considered HCWs needed to know, and be able to do as practical tasks for confident and competent work performance. It was understood, and made plain at the beginning of every meeting, that we were interested in their views and experiences in working with HIV/AIDS and what they thought, on the basis of those insights, should comprise the agenda material for subsequent discussions about curriculum development HCWs in tertiary education institutions. In making the arrangements for the meetings we sent an outline of what we wanted to focus group discussions upon, as shown in Figure 1 below–

Memorandum to key contact people in health care discipline areas

With regard to the content and proposed process of the focus group discussion with yourself and other colleagues the following notes are intended to provide a guide to the key questions and the structure of the activity, which is based on an hour and a half timetable.

Our purpose is to tap into your thinking and experience based knowledge, to represent the view of your discipline as to what tertiary education providers ought to take into account in the design and development of curriculum in preparing workers to perform their duties both confidently and competently in the HIV/AIDS field.

Figure 1 continued overleaf

Figure 1 continued

The first part of the focus group discussion deals with your thinking in a general overview way on three related topic areas-

- **THE AFFECTIVE DOMAIN**, that is, the ways you think HIV/AIDS education programs provided by tertiary education institutions for health care workers in the discipline area should set about socialising them (through education, training and professional development) to deal with the highly personal nature of HIV/AIDS work involving the feelings, emotions, self concept and identity of clients and others closely involved.
- **THE GENERAL KNOWLEDGE DOMAIN**, that is, that of a "must/need to know" kind relevant to the discipline for confident and competent work in HIV/AIDS which you might reasonably expect tertiary education programs to cover.
- **THE SPECIALISED SKILLS DOMAIN**, that is, those very specific discipline related skills involved in HIV/AIDS work with clients, partners, families and others which you might reasonably expect tertiary education programs to cover.

The second part of the focus group discussion is intended to get you thinking much more specifically about these three areas of curriculum design and development by asking you to focus attention on the following types of learners and levels of tertiary education programs-

- Health care workers in the discipline **new** to HIV/AIDS work
  (1) Neophytes
  (2) Experienced workers learning about HIV/AIDS for **the first time**
- Health care workers in the discipline with experience of HIV/AIDS work who are seeking some **updating** of their knowledge and skills.
- Learners about HIV/AIDS undertaking education programs at the **undergraduate level**
- Learners about HIV/AIDS undertaking education programs at the **postgraduate level**
- Learners about HIV/AIDS undertaking **"In-house" and in-service** education programs at any level
- Learners about HIV/AIDS undertaking **pre-service and/or non-graduate award education programs** (if this is applicable to the discipline area)

Figure 1: Tertiary Education Institutions Curriculum Needs Assessment: HIV/AIDS Health Care Workers

This approach and the use of an accompanying model (*Background paper* 4) encompassing the range of programs and types of learners in a matrix format worked quite easily and there was little need to elaborate upon the meanings of key terms, except to agree on common understandings.

To help the respondents keep their focus on the knowledge and skills they used in the work in HIV/AIDS we also used another model, intended to quickly identify what we wanted the respondents to do, as shown in Figure 2 on the next page.

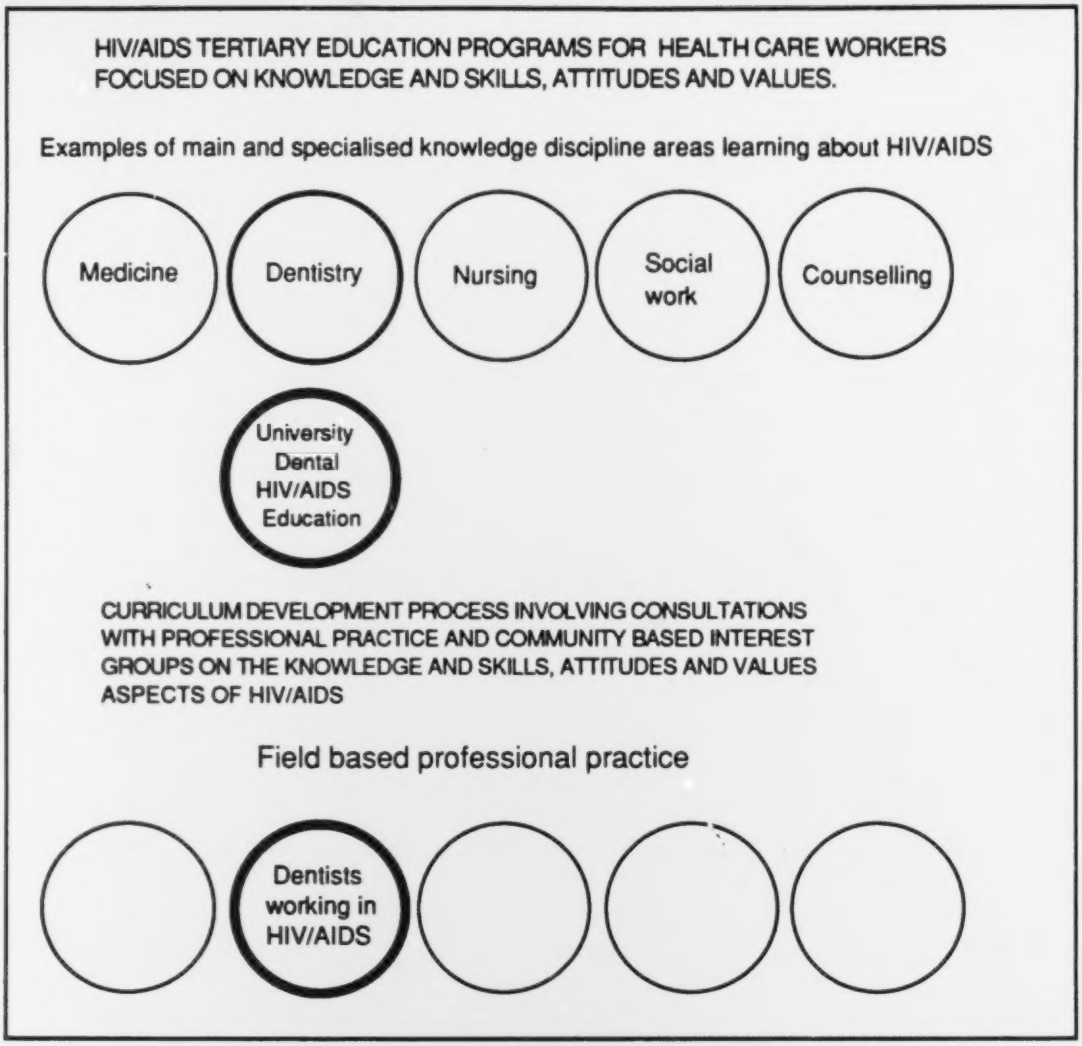
HIV/AIDS TERTIARY EDUCATION PROGRAMS FOR HEALTH CARE WORKERS
FOCUSED ON KNOWLEDGE AND SKILLS, ATTITUDES AND VALUES.
Examples of main and specialised knowledge discipline areas learning about HIV/AIDS
Medicine
Dentistry
Nursing
Social work
Counselling
University Dental HIV/AIDS Education
CURRICULUM DEVELOPMENT PROCESS INVOLVING CONSULTATIONS WITH PROFESSIONAL PRACTICE AND COMMUNITY BASED INTEREST GROUPS ON THE KNOWLEDGE AND SKILLS, ATTITUDES AND VALUES ASPECTS OF HIV/AIDS
Field based professional practice
Dentists working in HIV/AIDS

Figure 2: Schematic model used to focus attention in discussions
(example used with dentists at Adelaide Hospital)

FOCUS DISCUSSIONS WITH OTHER GROUPS IN HIV/AIDS

The second major phase of the fieldwork involved focus group meetings with two other sets of people, as shown in table 1. For these meetings we used a simpler format focussed on five main questions, essentially dealing with their perceptions and experiences of the health care services and professional workers at the delivery end HIV/AIDS provision. We regarded this data as important supplementary material to that obtained from the professional practitioners, throwing light on the personal aspects of provision and care, which we considered as valuable anecdotal as well as concrete data on the psycho-social domain of HIV/AIDS. The questions we used are shown in Table 2 on the next page.

Table 2: Questions to HIV/AIDS Community Interest/Needs People and Groups
(example based on focus group meetings with HIV positive people living with AIDS)

Q1 In your living experience with HIV/AIDS which of the following kinds of health care workers do you deal/work with most often?

- Doctors (any particular specialities?)
- Dentists
- Nurses (any particular specialities?)
- Allied health care workers (such as Physiotherapists/Occupational therapists, Dietitians, etc.)
- Social Workers
- Counsellors
- Others (please name them)

The following questions focus on your views of the educational and training needs of the health care workers involved in HIV/AIDS work you have identified above.

Explanatory note: the following questions are addressed to representatives within the affected community, as an example. The same type of questions were addressed to all other categories subject to some modification to language, as appropriate.

QUESTIONS ONLY FOR HIV POSITIVE AND PEOPLE LIVING WITH AIDS

Q2(a) What have been the **best** things you have experienced in your dealings with health care workers in HIV/AIDS-

- in getting **access** to health care services?
- in the way they **related** to you?

Q2(b) What have been the most **difficult** experiences you have had with health care workers

- in getting **access** to health care services?
- in the way they **related** to you?

Q2(c) What are the things you would like to make sure HIV positive and people living with AIDS **never have to experience again** in their relations with the health care workers you have identified above?

Q3 Thinking about the health care workers you have identified above, what attitudes, knowledge and skills would you want them to have to work effectively with the kind of HIV/AIDS matters you are involved in?

- I would want them to have the following **attitudes**:
- I would want them to have the following **knowledge**:
- I would want them to have the following **skills**:
- I would also want to see these things happen:

DATA ANALYSIS

A simple approach was used which reduced the content of the focus group discussions to a set of notes taken by the research team, either two or three members depending upon availability (*Background paper 2*). The case notes were written up afterwards and then edited into one text for our records. This procedure was repeated for each focus group discussion which then produced sufficient data for us to start to compile a series of thematic summaries for the

basic report and provide the cues for an overall interpretation of the curriculum implications for tertiary education programs for health care workers learning about HIV/AIDS.

ADDITIONAL DATA

Not all of the data was derived from focus group discussions. Such data, as that from our correspondence with the tertiary education providers in SA, was collected before we started the focus group discussions and put on hold for later use (*Background paper 3*). Moreover, some of our respondents at the focus group discussions were willing to take the matrix model away (*Figure 1 and Background paper 4)* for later completion after due reflection and return to the research team. This approach worked well for nurses dealing with AIDS patients at a key public hospital, for nurses attached to the gynaecology and midwifery unit at a specialist hospital, but most of the other respondents had difficulty slotting their practical and applied knowledge and skills into such a tight and seemingly pre-determined framework, which was quite understandable given the complexity of the model. Most of our respondents then, while happy to reflect upon their views and experiences in a general and anecdotal way were not comfortably drawn to prescribing what the specifics of a tightly designed curriculum for their kind of HCW at different points on the learning curve should look like.

The next section (three) of the report summarises the key findings from the focus group discussions followed in the concluding section (four) by our interpretation of the data in terms of curriculum development implications.

Section Three: Reporting the Main Findings

The following are the key points of emphasis concerning what professional health care workers regard as important tertiary education knowledge for competent and confident practice in HIV/AIDS service provision. Please note that what follows is an interpreted and edited account of the data supplied by the various informants. What we have done is to identify the salient points made by each focus group, not all of the ideas they presented to us. This means we have edited out many of the same points made by other focus groups, to avoid repetition and too much overlap.

Indeed there was a large amount of corresponding ideas shared between groups, perhaps because the different professional disciplines and occupational cultures have been able to converge on the problem in a largely similar way. At the same time differences of perception between professional disciplines do exist, because of the varied influences of each culture, and we also noted a healthy capacity for divergences of opinion between individual HCWs. For more on the thinking of each focus group please refer to the case study notes in *Background paper 2*.

The main ideas are presented here in the three knowledge domains used to structure and focus the thinking of our informants.

AFFECTIVE KNOWLEDGE DOMAIN

Main ideas: * Possibly applicable to all kinds of health care workers
Only applicable to the specialised health care discipline (mainly clinical)

* Human Values Education (HVE)

Ideally the HIV/AIDS education and training curriculum for all kinds of health care workers (HCWs) should focus on the comprehension and clarification of personal values so that the professional caring role is non-judgemental and does not come between the needs of the client/patient in the provision and delivery of services and support. HVE is intended to assist in HCWs come to terms with their own attitudes and personal values so that they can learn about and reflect upon their own likely fears, beliefs and prejudices in order to begin the continuous process of relating positively and effectively with HIV/AIDS clients/patients and significant others. Learning from practical

involvement (experiential learning) is regarded as particularly valuable as a means of putting into effect and reflecting in a real life context the benefits of sound preparation of HVE. *Note*: there was a variety of opinions as to whether HVE should be an independent curriculum module or incorporated into a program on human sexuality or inter-personal communication skills.

Practical examples of Human Values Education in operation

District Nurses: home based nursing requires the capacity to relate positively to the needs of others and appreciate their lifestyles in a non-judgemental and flexible way.

Clinical Nurses: the intensity and proximity of patient care requires the capacity to be involved safely and comfortably at both the physical and personal level.

Nursing in Gynaecology and Midwifery: the practice of universal precautions has to be balanced in terms of the degree of safety measures taken according to the known extent of risk and the particular needs of the patient.

Family Planning Workers: human sexuality is a complex area of human behaviour and requires of professional workers privy to intimate knowledge of other people's lives and lifestyles a high level of self awareness and integrity in role relationships.

Palliative Care Doctors: having the personal awareness and stability to go beyond the need for universal precautions to relate (as human beings) to the needs of the hospice patient.

Social Workers: HIV/AIDS has to be understood in a socio-cultural context not just as a health and disease matter.

Radiographers: a high level of personal awareness is required to judge the risk factors involved in patient care, especially in trauma and "wet" situations, so that safe practice and good interpersonal relations are part of the same process.

Physiotherapists: require good interpersonal relations skills to facilitate their role which is perceived as more compartmental than any other HCW. They perceive that they are less likely to be involved in forging close relationships with clients.

General Practitioners: this aspect of knowledge is the most important area of learning and education in HIV medicine. HVE underpins the idea of best practice regarding clients consent and understanding of all treatments including counselling, pre/post testing, and the practitioner's awareness of their own identity and relationships, and ability to advocate on behalf of HIV positive persons.

GENERAL KNOWLEDGE DOMAIN

Main ideas: * Possibly applicable to all kinds of health care workers
Only applicable to the specialised health care discipline (mainly clinical)

Universal Precautions (UP)

Knowledge of the contextual background, that is, the need for and correct use of the safety measures in a medical/clinical setting. The use of UP should be grounded in knowledge of infectious diseases relevant to the nature of the health care role and discipline, primarily in a clinical setting, and the kind of inter-personal involvement with the patient. The use of UP should also be based on knowledge of HIV and opportunistic diseases through an understanding of bio-physical science which includes transmission, presentation, progression and prognosis. The use of UP also needs knowledge of treatment and control of HIV/AIDS and an awareness of the language and myths used to label the disease in a social as well as medical/health context. The implementation/application of UP necessarily involves professional judgement of the degree of personal risk set alongside the need to relate positively and in a human way to the patient.

Practical examples involving the use of Universal Precautions:

Doctors: in general practice, acute medical/surgical/emergency care, palliative care or any field of practice or clinical management there is the need to have a sound knowledge base grounded in science of the disease and interpersonal communication skills to ensure delivery of safe practice.

Nurses: involved in hospital or community based practice need to have a sound knowledge base (as above) to ensure safe practice

Physiotherapists: are perceived as being required to treat muscle and skeletal symptoms related to the client's general ability and living independence.

Radiographers: in hospital based practice including emergency admissions of patients, need a knowledge base of the HIV disease process (and the HVE/communication skills) to support the proper implementation of universal precautions for all patients with unknown/undisclosed histories in the event of risk of infection through the patients blood loss in trauma cases.

Dentists: need high level of understanding the proper use of universal precautions, high level of diagnostic expertise, and an ability to facilitate oral hygiene behaviours in clients.

Clinical Management

This was expressed in the context of the project as the use of precautionary measures, drug therapy, investigations and dealing with grief. The exact nature of the meaning of clinical management depends upon two factors, the first being the specific practices of each health care discipline and the second the requirements of the multi-discipline team based approach working in a variety of contexts (such as hospital, hospice, home and community setting).

Practical examples involving Clinical Management:

Nursing (Infectious Diseases): nursing with safety while being focussed on achieving best practices in patient care according to standard procedures and special orders, and the particular needs of individual patients, thereby achieving holistic patient care.

Palliative Care (Medical Doctors): pain management through drug therapy and the establishment of supportive human environment with a quality of life focus on the needs of individual patients.

Gynaecology and Obstetrics (Doctors and Nurses): ante-natal identification of HIV infection leading to the implementation of specific protocols of patient care on a team work basis. This strategy arose from a senior nurse anticipating the need for specialised care and organising a staff development program to equip the care team with the requisite knowledge and skills.

Physiotherapy: focussing on the needs of patients for optimal mobility.

Radiography: undertaking procedures ensuring safety for patients, self and colleagues.

* Knowledge and Use of Services and Support in HIV/AIDS

Defined in the study as comprising these groups-

- for staff and "at risk" workers
- for the person with HIV/AIDS
- or others (partners, family, etc)

The meaning of the term embraces knowledge of what services and supports are available and the quality of such provision. It also includes an understanding of the accessibility of the services and supports and how people are treated by the providers when they seek help.

Practical examples involving knowledge and use of Services and Supports:

Haematology: staff require counselling and support in dealing with the risks and consequences of blood contamination affecting special patient groups such as haemophiliacs.

Health Care Workers: need to be aware of services and supports to encourage referral and use of support groups, such as the AIDS Council.

* Continuing Education of HIV/AIDS Workers

This means the updating of knowledge about HIV/AIDS in terms of scientific and medical discoveries and advances in treatments; variations in the manifestation of the disease by gender, age and other social characteristics; patterns of transmission; the socio-political context of HIV/AIDS service provision; and biographical accounts of the experience of the disease.

Practical examples involving the need for continuing education knowledge of HIV/AIDS from a variety of discipline perspective's:

- All health care workers reported the need for continuing education as an essential part of professional caring.

Medicine: Science and pathology updates needed to track the disclosure of the nature of the virus. HVE was seen as an ongoing requirement for the profession.

Nursing: Continuing education was required to update, inform and focus requirements for best practice.

Allied Health: Continuing education was necessary to remain informed and focused on the skills of caring.

* The Legal and Ethical Background of HIV/AIDS

This means an awareness of the litigation risks arising from the failure to follow proper occupational health and safety guidelines in dealing with HIV/AIDS patients in a clinical setting; a proper knowledge of the need for confidentiality and safeguards over disclosure of sensitive information about patients/clients extending into the wider community; and an avoidance of professional practices that might cause discrimination and therefore additional stress to HIV/AIDS patients/clients, and their significant others.

Practical examples involving knowledge of the legal and ethical background of HIV/AIDS work in a medical/clinical and community setting:

Radiography: litigation risks arising from situations where the practice of universal precautions does not cover every possibility of infection and cross infection, and where staff do not properly follow UP guidelines.

Aboriginal Health: the need to maintain strict confidences where the problem of social marginality would be compounded by community knowledge of the sexual practices and identities of HIV/AIDS aboriginal people.

Health Agencies: the need to educate HCW on the implications of organisational and procedures policies regarding universal precautions and occupational health and safety.

SPECIALISED SKILL DOMAIN

Main ideas: * Possibly applicable to all kinds of health care workers
Only applicable to the specialised health care discipline (mainly clinical)

* Interpersonal Communication Skills

These are designed to operationalise HVE by training HCWs in such skills as active/passive listening; the capacity to discuss openly and non-judgementally issues like sexuality, drug use, lifestyles, death and dying, grief and loss; an awareness of the effects of social stigma and discrimination and other forms of labelling and stereotyping; being able to keep confidences, build and maintain trust; and other counselling skills and behaviours such as empathy with, respect for, and the empowering of others to make life choices. Essentially the nature of patient/client care in HIV/AIDS requires HCWs to communicate

effectively on the basis of trust and reciprocity while being able to work safely as the circumstances demand.

Skills in Teaching and the Facilitation of Learning

These are intended for those HCWs with supervisory, mentoring, instructional and general education roles and responsibilities. There are two main points of emphasis. The first is in the skills of clear explaining of concepts and practices relevant to the needs of each health care discipline. The second is in being able to help others learn from experience and the reflections of theory and practice.

Notes:

(1) The Aboriginal health workers in HIV/AIDS used a story line approach to the expression of ideas which they regarded as more suited to the ways of communicating in the Aboriginal community generally.
(2) Some HCWs advocated the greater use of field based practitioners in HIV/AIDS work to teach within tertiary programs.
(3) Some also advocated greater use of HIV positive people as teachers and peer educators.

Specific Discipline Skills

These focus on the concerns of each professional discipline to act practically and competently in specific situations where knowledge has to be applied in a real life context in HIV/AIDS work.

Physiotherapists: helping the patient achieve mobility and independence within the constraints of the stage and condition of the disease.

Blood Transfusion Workers: being able to technically minimise the risk of cross infection owing to insufficient screening of blood causing product contamination.

Dentists: being able to accurately diagnose oral health requirements at the onset of HIV to act preventively as successful treatment at a later stage of the disease is apparently very difficult.

Palliative Care Workers (Doctors and Nurses): being able to give the right kind of intervention and pain management treatments.

Midwives: being able to conduct correct antenatal identification and carry out subsequent special care processes, individually or in a team.

General Practitioners: being able to relate to clients in a non-judgemental way and to implement pre and post test counselling for positive living in affected persons.

Detention Workers: need to understand UP and harm minimisation, to support health care in the prison system.

Views expressed by official bodies about HIV/AIDS representing professional health care workers

Finally in this section of the report a summary account of two official bodies providing policy guidelines on HIV/AIDS for professional members is presented below

Complementary to the focussed group discussions, the search for interpretive data was undertaken by corresponding with various statutory or official bodies representing professional opinion and practice in the HIV/AIDS field. Of the four SA bodies contacted, two provided limited but useful insights, usually expressed through policy statements and practice guidelines, designed to assist practitioners do their work competently and safely.

Thus, for example, the executive officials of the **Nurses Boards of South Australia** (NBSA) indicated that registered nurses would need to be familiar with various policy guidelines drawn from different sources (such as the SA Health Commission; the Occupational Health and Safety Division of the Commission; and to detailed competencies identified by the Australian Nursing Federation for safe practice using universal precautions). Moreover, the NBSA influences the nursing education curriculum in tertiary institutions and operates a 'bottom line' policy to ensure that nurses have sufficient working knowledge of HIV/AIDS for the purpose of nursing care and public protection.

The **Australian Medical Association** (AMA) has a very explicit position on HIV/AIDS, to the effect that it is essentially a viral disease spread mainly through contact with infected blood and genital secretions, causing eventual fatal illness for those that acquire it. The AMA acknowledges the surrounding context of the disease, notedly the social and moral implications of its transmission and spread, but confines its opinions to matters of safe medical practice. Thus the AMA offer policy guidelines to ensure that the usual principles of notification and control of communicable diseases apply to HIV/AIDS, but goes further in more general terms to advise on such matters of

duty of care, the practice of universal precautions, the issues of confidentiality and discrimination, and the importance of evaluation and research.

Essentially the AMA has approached HIV/AIDS in a thorough going way advising on the need for prevention as well as the management of the disease, locating the medical practitioner at the centre of society's expectation that they will take entrusted responsibility for preventing the spread of the disease and for caring for those affected.

Both sources clearly reinforce much of what we were told by nurses and doctors working in the HIV/AIDS field.

Section Four: Conclusion and Final Comments

Having identified a number of ideas that the respondents regard as the "need to know" agenda for confident and competent working in HIV/AIDS, for health care professionals, it requires from the research team an interpretive response in terms of what their views imply for curriculum development without suggesting that there is anything deficient or problematic with current provision of HIV/AIDS education programs for health care workers, or seeming to overly favour and advocate any one interpretation over another, except for the purpose of fostering further discussion.

A REMINDER OF THE SCOPE OF THE STUDY AND LIMITATIONS

It was recognised that in the process of collecting the field data it was clear that none of the various professional workers and other respondents were in a position to comprehensively survey the HIV/AIDS educational and training implications of their views and experiences. They were not required to do so under the pressures and time constraints of the focus group discussions. A different methodology would have been necessary, more akin to a textbook examination of knowledge, from the applied and practical to the largely philosophical and theoretical, which was not our purpose. We were interested in their knowledge and skills in use, readily springing to mind and regarded as the basic necessities for good practice in the light of personal experience. Thus, for example, there is little reference to the medical science of the disease, or much, other than in passing, to the psycho-social context of HIV/AIDS, or to the refinements of interpersonal communication techniques with clients. These are the subject matter of extensive study and the deep insights of intensive experience, as well as the huge learning agenda that is involved with any of the health and personal care disciplines involved.

It should be noted that we are offering these views as a broad consensus with all kinds of health care workers, making no distinctions, therefore, between those with a medical science orientation, drawing upon the conventions of the positivist and empiricist approach to knowledge and understanding, and those with a background in the social studies disciplines, and for a growing number, with leanings towards post-modernist and existentialist philosophy.

This still leaves a number of HCWs who might reasonably regard themselves as schooled in the science traditions of sociology and psychology and the applied

fields of inquiry into human behaviour modification, such as social work and counselling. The health care professions are not strangers to the controversies of theory and the ideologies of practice. Nor is the field short of eclectics and pragmatists, long out of range from the dogmas of belief and one dimensional standpoints about the underpinnings and driving forces of professional and best practice. Hence our attempts at generalisation could easily come to grief, pleasing nobody.

THE KEY FINDINGS PRESENTED AGAIN AS A REMINDER

As a contribution to further discussion we offer two broad models of curriculum that have suggested themselves, both directly and indirectly, as a result of field work. But first it is useful to present the key ideas over which there was a broad consensus of viewpoints from the field regarding core knowledge and approaches to learning and understanding.

The Affective Domain

- Human Values Education

The General Knowledge Domain

- Universal Precautions
- Clinical Management
- Knowledge and Use of Services and Supports in HIV/AIDS
- Continuing Professional/Vocational Education of HIV/AIDS Workers
- The Legal and Ethical Background of HIV/AIDS

The Specialised Skill Domain

- Interpersonal and Communication Skills
- Skills in Teaching and the Facilitation of Learning
- Specific Discipline Skills

Figure 3: The thematic concerns for HIV/AIDS tertiary education identified by the professional workers and other respondents as important knowledge for confident and competent practice

LEADING IDEAS FOR A COMMON CORE CURRICULUM

Based on the summary above, we regard the following leading ideas as broad matters of consensus for an imaginary common core curriculum for all kinds of HCWs involved in HIV/AIDS work with a strong orientation to "hands on" care and other forms of direct involvement in a client/patient setting.

Experiential learning: One of the most often stressed points, was the need to learn about HIV/AIDS on the basis of practical and first hand experience

through involvement with patient/client care, to extend and make more real the lessons of the textbook and the lecturing of the experts, as it were, and to form the basis of problem centred learning. This view was not intended to diminish the importance of formally acquired learning but to complement it in tertiary education. It was acknowledged that as the actual number of identified HIV/AIDS people is quite small in SA one of the problems for the education and training of health care workers is getting enough practical experience to learn from clients and their needs. It is also worth noting the risks of over researching such a small number of HCWs and clients.

Understanding personal responses to direct involvement in HIV/AIDS work: this is essential so that personal attitudes about the sexual and social behaviour of others does not become discriminatory and get between the provision of equal quality care and services to patients/clients and their close or significant others.

This perspective is the foundation stone of an holistic approach, and specifically, Human Values Education (HVE) in HIV/AIDS education and should be the basis of all kinds of health care work (both individual and team based) irrespective of the specialised knowledge and skills of particular disciplines. It was expressed to us several times that the problem of relating to HIV/AIDS patients/clients in an open, non-judgemental and non-discriminatory manner was still a major concern, some years after high levels of fear and ignorance among HCWs, other workers and the general public had peaked. We were in no position to verify this statement, of course, but to note the consistent way it was reported as an area for educational consideration in curriculum development.

Essentially HVE in this context is seen to be about helping the HCW at any stage of their professional development confront and better understand their own reactions to people whose health condition and background of psycho-social behaviour disturbs one's personal sense of the normative and value order underpinning human life. There are many disturbing and confronting situations in the world of health care but HIV/AIDS has been prominent in recent years as the issue to challenge ideas of professionalism and personal integrity in relation to those in need who may spark off deep fears and feelings of rejection, just like the plague may have done hundreds of years ago, in less informed times. In a much wider sense HVE is about the process of transcending ignorance and developing a world view based on the ideas and values of cosmopolitan knowledge.

Consulting and collaborating with HIV positive people as sources of *inside knowledge* and everyday experience of living with the virus. This point is not universally shared or understood as a practical action but there seems to be some agreement that in the learning and teaching process, at least, there is value to be added from such an approach in the tertiary education and training of HCWs. Such an approach should be regarded as complimentary to their experiential learning and generally as a practical means of fostering human values education.

Focusing on the person and the disease as an integrated approach to the management of treatment and care. Expressed in the most basic way, and as an illustration of what is meant, the dentist, in the early and preventive maintenance of the oral health of HIV positive person, needs to know the person through the mouth, as it were, and not only focus on dental treatment. This means the best of the dental chair and care approach, that is, time naturally and comfortably spent talking to the person sitting in it about whatever comes to mind and exercising universal precautions with tact and awareness. The same goes for every kind of HCW, and, of course acknowledging that we all have our personal likes and dislikes of other people we have to relate to in the course of our work roles and responsibilities. Essentially we understand that the majority of HCWs recognise the significance, as an integral part of the care giving, of engaging in the interpersonal relations aspects of their work with clients/patients as equal human beings, not from some lofty position of superiority, which almost invariably leads to making value and normative judgements and acting in a discriminatory way, even if this is done unconsciously.

Implicit in this picture, but worthwhile highlighting as an active and unifying principle for the education and training of HCWs and their professional practice, is the commitment to **quality care**. As an abstract idea it has appeal, for its value is hard to resit. It also translates into a set of criteria or benchmarks as the basis of an understanding of best practice, dangerously so if the spirit of quality care gets reduced to a set of rigid and aridly deterministic competency standards, which are a long way from the fostering of human ordinariness we mean by working towards positive relations with HIV/AIDS people. Hence the operational aspect of quality care needs to be approached with sensibility and sensitivity to fit around the human value world that seems to be desired by HCWs.

Related to the ideas expressed above is the value of approaching the HIV/AIDS work on a team basis, extending outwards to a network of others with knowledge and resources to share and exchange. This process is clearly underway but needs to be constantly promoted, supported and activated.

These background ideas appear to be acceptable key elements of a curriculum for HCWs involved in HIV/AIDS work and in that way they provide the building blocks for any change and development process that might ensue, after due consultation.

CONCLUSION

In our view the central issue of curriculum development, that is, judged from our own inside and experienced perspective of tertiary education, lies more with the question of whether HIV/AIDS education programs should be integrated into wider frameworks of knowledge and learning (**model 1**) or more fully developed as a specialised subject in its own right (**model 2**).

As a background to these two models we recognise that other relatively new health care concerns, such as palliative care, or the established ones, have a claim for an exclusive curriculum on the basis of the accumulated body of knowledge and learning which can be reasonably argued as the basic needs of informed practice and the basis of advancing the quality of care provision. We can also appreciate that the teaching of HIV/AIDS need not be reduced to an either/or decision, for it would be understandable to incorporate some of the basic knowledge into learning subject matter such as infectious diseases, sexually transmitted diseases or even into a more general approach, such as human sexuality.

Another form of curriculum organisation might be between those HCWs with their knowledge base located firmly in the medical sciences, notably, but not exclusively, doctors, dentists, nurses and the other allied health services, centred on the complex functions of the modern hospital and the increasingly technically based consulting rooms and surgeries. Clearly their orientation is primarily on the diagnosis and treatment of the viral disease and its symptomatic manifestations within the paradigm of medical science and the associated professional codes of practice. The emphasis of human relations values and skills will invariably be a secondary concern, but assumedly not an invisible or neglected one. In our view these professional workers are the object of the advocacy of a focused emphasis on the human relations aspects of a

curriculum designed to assist them to be more confident and competent in this key domain of HIV/AIDS work. It is an argument essentially about a more consciously balanced relationship between two ways of relating to people with HIV/AIDS; the perspective of medical science and the perspective of human relations.

VENTURING FORWARD

Returning to the main argument it has been expressed to us strongly that HIV/AIDS is a disease of growing worldwide significance, with no medical science cure in sight, and its rapid spread into the heterosexual community, already evident in Africa, will make increasing demands on health care resources. Hence the need for comprehensively educated, trained and specialised human resources able to work in the field with real competence and confidence. Looking beyond the short term and the obvious cost implications, the argument is a good one and cannot be ignored.

For the sake of argument, we tentatively favour the view that HIV/AIDS, both as a consequence of the spreading nature of the disease and because it clearly is a growing body of knowledge calling for specialised skills and understanding, should be discussed from this point in our report as a curriculum subject in its own right (**Model 2**). Our purpose, therefore, is to take this point of view to those academic staff in SA tertiary institutions with curriculum development (program design, teaching and learning) responsibilities to test their reactions, both to the argument and with proper regard to the contextual practicalities, for these matters obviously involve other considerations and decisions of an institutional politics and cost nature.

Leaving those matters aside (most impractical) the ideas presented above comprise some of the main outlines of a curriculum development change process. The material is of such general value that it could provide the core of a basic program for any kind of HCW irrespective of their primary knowledge paradigm and practice orientation. Clearly this still leaves plenty of scope for advanced and very specialised knowledge and skill formation at the highest reaches of our current understanding and learning about HIV/AIDS, most certainly in those health care disciplines that are focused on the medical science paradigm, such as the work of the physician and the dentist.

We leave this embryonic discussion with the thought that any attempt to change curriculum has to address the concerns and needs of those staff

responsible for managing the process of design and development. In the next stage of the project we shall focus, therefore, on both the curriculum structure/content questions and the concerns and needs of tertiary education staff as dual starting points.

BACKGROUND PAPERS

Background Paper 1: from the HIV/AIDS Programs Unit, South Australian Health Commission, 1992.

The purpose of this brief paper, written especially for the project, is to provide relevant contextual and background information about HIV/AIDS training for health care and allied workers which will illuminate the Tertiary Needs Assessment. This paper will describe relevant background history and outline the issues and concerns of the HIV/AIDS Programs Unit which led to the commissioning of the Tertiary Needs Assessment.

The first diagnosis of an HIV antibody positive person in Australia was in December 1982. Since that time, health care and allied workers have publicly expressed their concerns about their safety and the required skills to work with people affected by HIV. "The Grim Reaper" media campaign (1987) succeeded in alerting the public to the presence of HIV infection, but one unfortunate outcome was that the campaign increased people's unnecessary fears and enlivened a mythology about HIV and AIDS that educators have needed to address in their programs ever since. Educators who ignored this aspect of HIV and AIDS did so to the peril of their programs. Myths and fears of workers needed to be acknowledged before they were willing and able to learn.

Health care providers were not beyond the reach of the media. Those employed in the health industry were equally affected by visions of pestilence and plague that they feared to be the result of supernatural forces. In those early years some health professionals called for mandatory HIV testing, law to deter transmission, the introduction of unwieldy and unnecessary barrier precautions and quarantining of people with HIV or AIDS. Other health professionals quietly adopted universal precautions and applied their knowledge and experience to acquiring skills in working with people affected by HIV.

In South Australia, the first state planned response to the education of health care and allied workers was in 1988 with the establishment of the AIDS Education Unit. Three educators worked under the auspices of STD Services until 1990 when they were disbanded. The two day program "AIDS in you Workplace" and "AIDS—Three Day Counselling Intensive" enabled workers to explore their attitudes and values and provided basic education and skill development to a broad cross section of 1200 workers. The training also targeted key educators of institutions in order to widen the reach. In 1990, the current HIV/AIDS Programs Unit was created under the AIDS Matched Funding Program and resulted in the dissolution of the AIDS Education Unit. Although STD Services took up the education of medical students and GPs on placement, this left South Australia without a focus for broader health care worker training and also without a comprehensive strategy to address the education needs.

In implementing the "National HIV/AIDS Strategy" 1989–1993, the Commonwealth Department of Health, Housing and Community Services (DHHCS) funded the Commonwealth AIDS Workforce Information Standards and Exchange, (CAWISE) program. Funding was made available for the development of training and resource materials which were of national significance. Few projects in South Australia were funded under this scheme

but the state fared better under another more flexible body of funding made available to people working with those infected and affected by HIV or AIDS—HIV/AIDS Study Grants. Here, individuals such as doctors, voluntary carers and nutritionists were assisted to access special training and resources not necessarily available in this state. This has certainly underpinned the skill level for some workers and has achieved secondary payoffs with the sharing of information among peers.

In this time, most education for health care and allied workers has been for those working in the field. The Tertiary Sector who are the initial providers of education for the health industry, were largely left to their own devices. In May 1992, staff of the HIV/AIDS Programs Unit wrote to the Director of Resources and Planning, Public and Environmental Health Service, SAHC seeking funding to undertake a needs assessment of HIV and AIDS education for health care and allied workers. The report was to describe current education in tertiary institutions. It was to inform the planning of HIV/AIDS education for health care and allied workers that will facilitate the most effective mainstreaming of HIV services in SA. The needs assessment will also facilitate discussion, networking and coordination among tertiary institutions, educators, the HIV/AIDS education field and health care workers.

Several factors prompted this decision. From the field came a number of indications that enquires was appropriate. There were requests for education and training sessions from a variety of organisations such as FACS Staff Development Unit, the Public Trustee, businesses in the private sector, a number of professional bodies and the health and related courses of the universities themselves. Educators, lecturers, staff development and OH&S trainers often said that they felt confident with the technical information but at a loss in working with the human and social implications of HIV and AIDS. Neither was it easy to discuss ethics and policy development in a field where personal, social and scientific change was the daily companion of coalface workers. Clearly educators felt there was a gap in their skill base which inhibited them from working confidently with the issues raised by HIV and AIDS in their sessions.

Workers in agencies interfacing with people at risk of HIV requested information and training in medical, communication, counselling, sexuality, drug use and other skills required by those working with HIV and AIDS. With the demise of the AIDS Education Unit of the South Australian Health Commission in 1990, there were no easily identifiable training resources available for workers to access.

There was an increasing number of complaints made by HIV affected people about discrimination experienced in health care and allied services. The AIDS Council of SA (ACSA) and the Commission for Equal Opportunity are both involved in receiving and dealing with such complaints. As well, a number of complaints were received by workers in agencies about the behaviour of other colleagues and the lack of adequate HIV/AIDS policy or training available to them in their agency.

At a planning day in April 1992 concerns were expressed by advisory groups to the HIV/AIDS Programs Unit, the Education & Prevention Task Force (EPTF), and the Treatment Counselling & Support Task Force (CTSTF), about the need for the ongoing HIV/AIDS education of health care and allied workers. If a 'worst option' mainstreaming philosophy without provision for specialist HIV/AIDS funding, resources and service delivery were adopted, a priority

needed to be given to the education of workers. Indeed, even with dedicated program and funding available, the Task Force identified the education and training of mainstream health and allied workers as a top priority for both the long and short terms.

There is no agreed comprehensive strategy in SA for the HIV/AIDS education of health care and allied workers. A number of learning opportunities for health care workers have been provided by projects generated from Matched Funding (summarised in the following pages).

1981 to 1992: Health and Allied Worker Education in SA

The twin goals of the National HIV/AIDS Strategy (1989) are:

- to eliminate transmission of the virus; and
- to eliminate their personal and social impact of HIV infection

In line with the National Strategy and in the face of threats to ongoing HIV/AIDS Programs Unit determined to ensure appropriate HIV/AIDS education in the tertiary sector which feeds service delivery. The first step was to take a census on what had been developed and established in both the tertiary sector and service area in the community which might impinge on the quality of education for health care providers.

Relevant projects funded by Matched Funding or from Commonwealth sources over the last decade are:

1988 to 1990: AIDS Education Unit

A team of three educators developed and provided training for a wide range of health and community professionals which included 2 and 3 day workshops "AIDS in your Workplace" and "HIV/AIDS Counselling Intensive". They devised experimental adult education models which included innovative work on values and attitudes. People living with HIV and AIDS provided consultancy to the programs.

1988 to present: HIV Antibody Positive Consultants

From the earliest days, the AIDS Education Unit worked with HIV positive people who were paid to contribute their knowledge and experience to education and training. Subsequently, guidelines were developed, and training was offered to these educators, to support their need for confidentiality and skill development. In South Australia, many education projects accessed their expertise and subsequently, ACSA took responsibility for their support and training as a team. They continue to be the most valued resource for education and training programs by both facilitators and participants.

1989 to present: Clinic 275—STD Control Branch

The STD Clinic has traditionally provided HIV/AIDS consultation and education in the context of STDs from the earliest days for medical students and other health professionals on placement. They have provided training for key sexuality educators in rural areas in a joint project with FPA and also developed a course for training GPs in HIV treatment skills and issues.

1989 to 1992: Child and Adolescent Family Health Service

Funded to run training programs state wide to develop a network of HIV informed clinic nurses available to resource schools, children and parents.

1989: Youth Sector Training Council

Developed models and provided one and two day programs for workers with young people. The programs focussed on accurate information, values clarification, exploration of ways to encourage safe behaviour in young people and issues for agencies. The program also included a personal perspective on HIV from a person living with AIDS.

1989 to 1991: Family Planning Association (FPA)

Funded to provide train the trainer programs for workers with people with disabilities and workers with people from non English speaking background. With Clinic 275, they were involved in the training of key sexuality educators in rural areas.

1986 to present: Royal District Nursing Society (RDNS)

Developed outreach care services for people with HIV and AIDS education models to train staff. In 1992 they have offered skills and experience in a new education and training package for workers in the field.

1989 to present: Drug and Alcohol Services Council (DASC)

Has trained over 300 local government, welfare and community workers in health risk minimisation strategies in relation to injecting drug use. Licensed 120 to conduct needle and syringe exchange programs. They have developed education around the philosophy of harm minimisation and have worked in partnership with ACSA's SAVIVE peer education project to initiate new approaches to education and training.

1990 to 1991: Royal College of General Practitioners

Funded to develop and implement a state wide peer education program for GPs on HIV and AIDS.

1992: Flinders Medical Centre/University

A course has jointly been developed by the HIV/AIDS Liaison Officer at the hospital and the University School of Nursing to provide HIV/AIDS education to nursing professionals. Consultation and skills are also offered to undergraduate nursing and medical programs.

Ongoing: Hospital based Services

Were among the first to respond to the challenge of meeting HIV and AIDS by implementing training and adopting Universal Precautions. The education and staff development sections of the major hospitals draw on experienced ward staff in providing resources.

1991 to 1992: Aboriginal Health Organisations

Seven Aboriginal HIV/AIDS educators working in rural and metropolitan communities have been trained in "AIDS—A Story in our Hands". The program is culturally appropriate and based on a community development model.

Ongoing: AIDS Council of South Australia (ACSA)

Have provided training of volunteers to resource a care and support program for people living with HIV. They have offered considerable skill and experience in the provision of peer education programs to sex workers, men who have sex with men and injecting drug users. Their role as consultants to mainstream organisations and tertiary institutions is increasingly invaluable. Currently developing a training and education branch.

1992: HIV/AIDS Study Grants (DHHCS)

In 1992, three major projects were commissioned:

- Bouverie Clinic Five Day Counselling Intensive—trained 10 participants in HIV/AIDS Family Therapy counselling skills.
- Pre & Post Test Counselling—20 health care workers trained in pre and post test counselling skills by staff of Social Biology Resources Centre in Melbourne.
- ANF HIV/AIDS Train the Trainer for Health Care Providers—three day workshops in Adelaide, Whyalla, Mt. Gambier.
- Conscious Living, Conscious Dying—a workshop on the issues of grief and loss for educators working in the field. A two day workshop was held for HIV positive consultants who contribute their skills and expertise to the field.

Background paper 2: Summaries of Focussed Group Discussions.

Note: the following examples are based on our case notes written after the focused group discussions. They should be read, therefore, as rough notes which we used to summarise our findings and not as polished prose. As different members of the research team took and transcribed the notes there is also variation in the styles of expression.

Focus Discussion: Community Based Nursing

The Service covers SA regional and metropolitan areas but not those classified as Outreach. There are currently 17 patients (and 3 waiting) in care. The coordinator we met covers the whole area and her role includes clinical education and supervision of care in homes, education as a whole within RDNS.

There is a program in train for AIDS education where a full day workshop is run each month. Additionally a ten week course (1 evening a week) is offered as a fee-paying course with a multi disciplinary focus.

Key points:

1. Values clarification education is essential and guest speakers can be used to help the process particularly those who are HIV positive themselves. This adds reality and depth and breadth to levels of knowledge. Professionals in the field need to be at grips with their own issues in order to go forward in dealing with HIV/AIDS. Subjects include sex, drugs, death, grief, loss, and the use of language (non-judgemental).

2. Content should be largely designed across the three domains of knowledge (as depicted in the matrix model) and exemplars from the field enhances learning.

3. They believe that acquired knowledge/skills based on education and practice allow for continuation of knowledge and skills growth and development.

4. There needs to be equal balance of skills and knowledge in curricula, and facilitators need to be experienced and comfortable with students and the objective of the learning environment.

5. There is a maturational aspect to Values Clarification in learning which should be related to Undergraduate and Postgraduate type programs.

6. The area of values clarification does not appear to fit a Competency based curriculum or work discipline.

7. Necessary knowledge include the facts (science), the practice (nursing), universal precautions, politics of AIDS, a compulsory part of the curriculum, and integrated across other things such as Hepatitis B and sexuality, in care and education.

Focus Discussion: Hospital Based Nursing

It was clear that we were holding discussions with three very experienced nurses who had learned a great deal quickly about HIV/AIDS on the basis of intensive involvement in a caring capacity. All three were of one mind in emphasising the importance of experiential learning in coming to terms with their own initial lack of knowledge, deep seated fears and having to cope with a considerable amount of blaming behaviour by others infected/affected by the HIV virus, whether as a patient or an involved person. It came naturally to the nursing team, therefore, to give high priority to the value of education and training in the affective domain, both in a preparatory way through tertiary programs and by on-the-job instruction where the most significant learning takes place.

We discussed ideas of a general principle kind, which might be applied to the curriculum development of HIV/AIDS programs, arising from their initial observations about the importance of the affective domain in the socialisation of nurses, in particular as new learners to the field, but also for others as well.

Key points:

1. The need to foster an open minded approach to personal ignorance, fears and confusions about how to relate to HIV/AIDS patients and those close to them.

2. The need to let people express their feelings whatever they might be so that they might confront themselves and therefore deal more knowingly with real situations where it is very likely that nursing would present unanticipated coping experiences and learning opportunities.

3. The need to personalise the experience of dealing with HIV/AIDS by having direct care responsibilities as much as possible as an essential aspect of planned learning.

4. The need to know about proper precautions beforehand, "just like any other disease", but not let these prevent nurses relating positively to patients and close others.

5. "The need for a strong philosophical base" so as to handle conflicts arising within oneself and between patients and close others, as the basis for sharing the learning to reduce the ignorance, fear and prejudice factors.

6. The need for sexual knowledge so as to contextualise HIV/AIDS in a sociological way quite as much as a medical and clinical and to know how to use such knowledge as the means of sensitive human relations in an arena of behaviour subject to social stigma.

7. The need for knowledge of adult learning for so much of HIV/AIDS work requires the ability to explain ideas and the capacity to reflect on learning acquired through direct experience, in addition to the need to extend one's own systematic knowledge by further study.

These general principles led to discussion of a more thematic issue, that is, the desirable balance to be struck educationally between the proper need to systematise knowledge and support formal learning and the equally valid need to help nurses learn from experiential situations where dealing with human and clinical problems, often in a complex entwined way, would call for insight, fellow feeling, compassions, diplomatic tact and other interpersonal qualities which can only be learned from experience.

Discussion also focused on perceptions of role, albeit in a very general way, in which the early experience of nursing in HIV/AIDS, vis-a-vis other nurses and health care workers, as well as family and friends, produced a feeling of being something of a pioneer, and, at the same time, rather embattled, in having to deal with ignorance, fears and prejudice. The solution, such as it ever is, was to simply get on with the tasks and use the learning of experience as the best means of acquiring competence and confidence in HIV/AIDS work.

This perspective led to the view that the three nurses favoured a mixed ward setting for the treatment of HIV/AIDS, something between the specialised

environment of infectious diseases and those advocating a mainstreaming approach.

Finally, with regard to completing the matrix it was agreed that their ideas about the three domains do not match up with the boxes in quite such a schematic way. This point is understood and appreciated.

Focus discussion: A General Practitioner involved in HIV/AIDS

Key points:

1. That the RACGP policy document has better representation of general practitioners, in the view of the respondent, than the AMA which apparently may have only about 40 percent (for GPs).

2. That Undergraduate (UG) courses are not/should not be designed to turn students into general practitioners. They are basic and preparatory to post-graduate studies.

3. Regarding HIV the patient is a key source of education as they are usually young, angry and motivated and have been able to express their needs clearly and strongly.

4. With regard to keeping up with continuing education needs, learning comes mainly from reading journals on either nice/need to know basis and correspondence with specialists. There is little formal education although now there are specific courses in the Eastern States but had to do the course before being able to give the drug therapy (acyclovar). South Australia has not done this.

Focus Discussion: STD Clinic doctors involved in HIV/AIDS and the educational provision for general practitioners

General practitioners need education relating to the **Affective domain,** particularly in regard to issues related to discrimination, moral stance, IDUs, prostitution, concept of own/others mortality and appreciation of the feelings and living circumstances of HIV persons.

The emphasis of preparatory and continuing education should be in the affective domain but a necessary level of knowledge is needed about the medical

science such as the aetiology. A general sense of HIV needs to be in curricula and particularly at the level of learning Differential Diagnosis at an early stage of education.

The strongest influence on the development and learning about human values comes from socialisation of students by the examples of medical consultants. A consultant with negative attitudes effects negative attitudes in medical students and GPs. Therefore education needs to target "older consultants" in practice relating HVE to HIV/AIDS work.

Other key points about the education of medical doctors:

1. Medical students need to have a good idea about themselves and relationships as a core aspect of their education.

2. Ideally small group work should be used as the primary methodology instead of lectures.

3. All core curriculum items need to embrace HIV as one of the examples.

4. Needs a specialised focus as well, such as in Microbiology studies.

5. HIV is shifting the paradigm of medical treatment in general.

6. There is a kind of mini-renaissance in medical service, such as the Gay community empowering itself to demand better treatment than what was dished out to them in the past (discriminatory) and medicos have to revise their service in order to have adequate clientele through which to make a living.

7. Some doctors do not want HIV clientele. The reasons are lack of knowledge/experience in this area and decide to refer with no wish to care for people with HIV/AIDS.

8. Patient advocacy an important role for GPs because they have to deal with specialists, employers, housing trust and so forth.

Focus Discussion: STD Clinic doctors involved in HIV/AIDS

Key points:

The **Affective domain of knowledge** is by far the most important area of learning and education in medicine related to HIV (and indeed most other aspects of caring/treating). For example this area if hardest to deal with as opposed to learning about facts/treatment of the disease. Technical information is technical and really only needed at the level of treatment. Education for GPs requires knowing about HIV but not a lot of technical detail. Most clients would be very worried about having HIV and it is what this represents that more knowledge is needed. Included with this is the necessity to be able to test properly and this too is core knowledge

The idea of **best practice** was introduced in the context of matters of consent and understanding, meaning that this should be the guiding principle of teaching and learning for all treatments. It does not seem to happen this way and this is why it needs special focus in curriculum and should be a model for all practice.

Related key points:

1. Counselling with regard to pre and post testing needs to go by the ANCA guidelines and should include the science of the test (behaviour of the virus) and assessing the risk (the incident about which the person is worried). This is because in the past the person was told he or she was infected on a HIV test result because the interpretation was on antibody "result" incorrectly stating "immunity". Another instance is when a person is told that they are "not infected", because the test was negative, when the counsel should be "not infected when you had the test" (because of the "Window period" when test results are not in a definitive state of certainty).

2. Counselling time seems to be a problem in amongst a busy ward/clinic day when involved with admissions and the like. This wae regarded as a lack of time factor.

3. Counselling can be undertaken by someone else such as with counsellors employed to do so but it is morally wrong to leave this to someone else in your treatment/practice.

4. Communications and interpersonal skills problems seem to be the greatest blocks to adequate treatment. Clarity of information and process is needed.

With regard to knowledge of **Universal Precautions** this was defined as necessary general knowledge. HIV has highlighted the way for best practice principles. The implication of this point is that UP should be the knowledge and skill framework for applied learning rather than the HIV disease.

Key related point:

Fears versus nonchalance regarding needle stick injury etc but remember that this also applies to other infectious diseases particularly Hep-B/C, TB. and etc. The trend is for curricula to utilise a problem based learning approach particularly at post graduate level, and even the more traditional curricula are looking at ways of using problem solving methods for teaching/learning.

Focus Discussion: Medical Doctors in Palliative Care in HIV/AIDS

This interview with hospice medical personnel was the first to be undertaken for the project data collection. The respondents commented on the schematic model and the data matrix instrument, as being appropriate, useful and descriptive of what was expected in the focus group discussion.

With regard to **general medicine** it seems that the practice underpinnings in caring for people and HIV/AIDS comprise four main scenarios.

1. Safely handling body fluids, known as implementing universal precautions without fear for self and with respect for others.

2. People who believe they may have accidentally been infected with HIV.

3. People who suspect they have HIV/AIDS.

4. The people who care for those with HIV/AIDS.

The use of "universal precautions" when dealing with persons who have HIV/AIDS may be problematic at times. People may use these precautions fearfully and tremulously, or on the other hand in a "slap-happy" way. This sort of behaviour falls outside of expected normative behaviour and counselling of such personnel is imperative in order to facilitate working without fear, and

with due respect for client and self. The effectiveness of using universal precautions is important in caring for people with HIV/AIDS.

Using precautions, "Sharpens the mind once one knows (and can be) a comfortable way of relating even with gloves on". Learning positive, helpful attitudes to overcome symbols of untouchability as represented by gloves used in precautions.

When people think they have been accidentally infected (eg. needle stick injury) the situation requires that local mechanisms for review and immediate care be available and implemented. This means policy and guidelines of organisations should be clearly available and locatable.

Those people who think they might have HIV/AIDS whether staff (personnel) or patients (clientele) present with problems related to psychological processes and phobias, and need reassurance through opportunity in their learning to talk about HIV/AIDS. This aspect needs to be overtly handled not covertly dismissed.

In the respondents experience those caring for people with HIV/AIDS learn to be comfortable with relationships and physical caring by developing good relationships through involvement.

Earlier in his experience there was a bit of fearfulness but this is less observable now. Generally he believes that people with HIV/AIDS seem to be "nice" people, fun to work with, with interesting lives and friends. At the same time it was noted that this rather comfortable perspective would dramatically alter if the hospice were to care for a drug injecting patient with aggressive behaviour.

Carers in general need knowledge of symptom control, updates on drug therapy, sound knowledge of precautions, and of primary importance how to provide an environment which is supportive and not "different".

Doctors need skills in positive attitude development, sophisticated drug control, knowledgeable suspicion regarding symptoms, taking blood safely, counselling and dealing with grief.

Learners require/need the opportunity in training at all levels to explore the "whole thing" (HIV/AIDS).

The Palliative Care perspective is basically symptom control, ethical decision making (longevity), medication, providing a supportive environment for care of the patient, lovers, friends and family. He would expect undergraduates to have developed an index of suspicion regarding signs and symptoms. They would need to have a beginning knowledge of associated pharmacology, excluding sophisticated drugs. Technical skill, such as taking blood safely is essential. He believes that counselling skills and dealing with grief should be a skill in acquisition.

Other key points:

Medical personnel in palliative care need to be able to protect selves/other people; counsel people who may be placed at risk of contracting HIV/AIDS through accidental occupational (or other) injury (eg. needle stick); counsel people who believe they have HIV/AIDS; consider those who look after people with HIV/AIDS; counsel regarding, and teach universal precautions-need to be used without fear and with respect; ensure that adequate organisational policy and guidelines facilitate care of those with an occupational injury leading to risk of infection; help learners in training explore HIV/AIDS in the broadest sense, and develop mechanisms for comfortable relationships with people with HIV/AIDS

Focused Discussion: Specialist Medical Doctor Obstetrics and Gynaecology

An official educational program has been run now three times, regarding HIV/AIDS. The program covers care from the antenatal period to postnatal care and included termination of pregnancy. The programs were run while the experience was available (there was a patient "on the books"). Staff responded well apparently and there was only one case of conflict of interest in relation to husband concern.

The tertiary education sector has not to their knowledge been in contact with them in relation to these experiences and curriculum development possibilities.

Key points:

1. Obstetric/medical knowledge base related to women and HIV now at the stage of development that men and HIV was in 1982, and things are changing so quickly The main questions relate to whether the mother is

asymptomatic/symptomatic, whether the baby likely to be infected, and with what prognosis? Thus general knowledge is very important and students and carers must have access to information and education.

2. A general approach to teaching and learning in this area is the favoured way to go because of the need to know aspects of many other important infectious diseases such as Hepatitis B which is in fact much more common.

3. Doctors and Medical Schools have a problem to be addressed in that huge social change and scientific knowledge explosion has outweighed affective learning needs. It would seem that they need to balance science and clinical management so that interpersonal skills are a focus in care.

4. A team approach to care and education is important.

5. Confidentiality and the correct use of Universal Precautions are essential components of education and care delivery The affective domain should be part of these in education and application to the workplace.

6. Relearning for "old" medics is difficult but in-service should have the same objectives as above. Doctors seem to learn from nurses in the clinical field when they are neophytes especially.

Focused Discussion: Dentistry and HIV/AIDS care

The project on HIV/AIDS Education Needs was introduced and described in preparation for focus group participation. The Schema and Matrix were described by the participants as impressive and were taken (by agreement) for use in developing in-service education at the clinic.

Background: the clinic has treated 50 people in Stage 4 HIV infection (AIDS) and a "handful" in Stage 2, over the last 12 month period.

With regard to specialised skills Dentistry needs to:

- cultivate/educate people (dentists and assistants) with the necessary knowledge and capability in diagnosis

- address education and support needs of dental assistants and hygienists by understanding universal precautions for protecting self/others.

- form a supportive network with community support/interest groups for liaison and group support of patients.

- assist in reforming tertiary education courses so that undergraduates are able to practice competently in the field following graduation

- recognise that UG courses need to be upgraded so that students recognise the signs and symptoms of HIV/AIDS

- attend to the need for teaching and implementing in practice the competent and confident practice of universal precautions, because Dentistry knowledge base required to treat people with HIV/AIDS requires special knowledge and skills, and because optimal dental health prior to end-stage AIDS lends quality of life to the person with AIDS, and prevents severe discomfort of the mouth.

In general graduates have more opportunity to keep informed and updated. Postgraduates including teachers and supervisors appear to have less opportunity for this and may affect curriculum design and outcomes.

The major curriculum concern at all levels of education in dentistry appears to be in the specialised skills domain where detecting signs and symptoms and the practice of adequate universal precautions are perceived as needing attention. Following on from this, the concept of Infectious Diseases (general and HIV/AIDS specifically) needs to be included overtly in the curriculum. To enhance learning in this area clinical application in formal teaching sessions needs to be attended. This means that dental specialists rather that medical specialists may be the most appropriate teachers in the field of dental theory and practice.

In the Affective Domain it was asserted that dentists need to have a handle on patient management and patient behaviour, and that this area of curriculum appears to be adequate and working well in practice. With regard to continuing education programs at the Clinic, sessions are offered monthly and are run by the clinic staff. Rapid social change and expanding knowledge in the HIV/AIDS area have altered requirements for learning and gaining knowledge and therefore curriculum at all levels needs to acknowledge this.

Other key points:

1. HIV/AIDS (and other infectious diseases) education needs to be expanded in the UG curriculum, with special attention to recognition of signs and symptoms and implementing Universal Precautions.

2. Education and dental management in end-stage AIDS patients needs to be a focus in the curriculum at all levels of education.

3. The education of dental hygienists and assistants regarding HIV/AIDS patient care needs to be addressed.

4. A support network with community and other interested groups needs to be established.

5. Practising dental specialists need to be more involved in curriculum design and implementation.

Focused Discussion: Haematology workers talking about HIV/AIDS caught from infected blood

The project was revisited and further described in order to set the scene. The schematic model, data matrix, and interest group questionnaire were explained so that the group could focus on educational needs of health care workers with regards to HIV/AIDS.

The group described itself as representing the transfusion unit, liaison and counselling, and Haemophilia support group. They work from the perspective of transfusion medicine acutely aware of contamination of blood products, and the need to work ahead of any recommendations in the field. An historical catalyst for this relates to the period in the 1980s when four Queensland babies became infected with HIV causing national concern for the supposed safety of using any blood or blood product in medicine. It is still not clear whether the current heating (treatment) of blood is totally effective in destroying HIV in blood.

In the clinical sense they deal with people's fear of being infected resulting in AIDS, of being infected with Hepatitis B and C, and of contracting other varieties of blood related medical problems.

In addition, it appears that clinical treatment of Haemophiliacs (and others) is clouded by these issues:

- Whether the presentation of symptoms caused by the above infections or by haemophilia.

- HIV infection often presents differently in haemophiliacs such as seeing Karposi Sarcoma less often and Thrombocytopenia more often.

- Patient isolation because of social stigma (social perversion seen as the cause of HIV/AIDS) and these negative attitudes carried by HCW groups.

- Compounding this aspect of care, staff in the unit feel guilty because they administered the product. Staff need support and there is no official policy and practice related to this need. Staff overcome this through providing their own support in the form of social get togethers and discussion forums. This is seen to be very important because staff, significant others (eg. husbands) need care, information and counselling as well. The Haemophilia Foundation provides considerable support to them as well. A Federal Government grant was provided for nurses to address the problem of support requirement.

Those staff who work in haematology/pathology (Bench People) have a clinical orientation to the HIV/AIDS situation, and with little or no patient contact/relationship they are seen as difficult to assess in terms of their need for support. Clinicians on the other hand (eg. Nurses) are more people oriented in regards to their practice and the major skill concern lies with Universal Precautions knowledge and practice. They described the practice as a bit like "Safe Sex", that is, hit-and-miss-know about it but do not always implement it in practice. They believe this approach to Universal precautions puts pressure on those people infected who observe such practices and fear for staff safety. This practice leads to another aspect of lack of professional discretion, that is a problem with maintaining confidentiality of patient status/information. Such story telling in public places is seen to be devastating to infected people and their significant others. In clinical practice, preservation of confidentiality may be perceived as asking too much of humans under stress but it was felt that while this is appreciated, there is a time and place for such talk and this lies in implementing debriefing sessions.

Key points:

1. Significant fact that all kinds of people can be infected by medically acquired HIV/AIDS virus - not a disease of the peculiar or perverse.

2. Particularly traumatic experience to have cross infection which is very hard on haemophiliacs which produces a considerable fear reaction from further infection and a lack of trust.

3. Role of counselling is very important in helping patients, staff etc in dealing with their fears and loss/grief experienced over a long period of transition and change. For staff in IMVS there is the special problem of feeling responsible for unknowingly causing the spread of the HIV virus through blood transfusion - because of a lack of knowledge of universal precautions (not used as much as it should be).

4. Importance of professional integrity and discretion is not losing sight of the need for confidentiality because of the stigma factor and the chance of information being communicated to significant others. The role of education in this context is to teach the values and practices of discretion and confidentiality through problem solving and experimental approaches to learning starting with the personal and known

5. Other forms of knowing about underlying conditions, inter-relationships of conditions, gender differences, transmission and progression, latest findings and methods of treatment. These should be regarded as the foundations of experiential learning and the skills of active listening and liaison counselling

6. Respondents were not in favour of a specialised HIV/AIDS program.

7. Value of on-job-training prepared by good tertiary programs providing knowledge of a relevant background kind. Need to know - bio sciences/gender factors/transmission. Need to have skills in the affective domain by improving counselling and desensitising programs. Need to get close to how a person with AIDS feels and how it is necessary to be in touch with one's own value judgements.

Need counselling skills in dealing with patients who want to commit suicide.

Need to distinguish between barrier nursing and using universal precautions sensibly.

The approach to learning should be based upon 'real life' situations.

Focused Discussion: Radiography and HIV/AIDS

Key points:

1. A universal precautions approach is the policy for treating all patient until proven to be disease free. Some patients require little physical contact while others require much more, such as in severe trauma cases where the risk factor is regarded as much higher until diagnosis is made. This is also due to the presence of blood in handling such patients. *Note*: this takes into account the risks associated with other contagious diseases such as Hepatitis B.

2. Universal Precautions now hospital policy and part of Staff Development. The package is generally accepted but not implemented as it depends on professionals perceptions of their own risk behaviour. There is no real enforcement of UP and it rests with own judgement.

3. UP with gloves and other barriers appear to be offensive to patients not needing it so except in cases of special procedures it is questionable as to whether it is needed all the time.

4. The approach (gloves or not) is due to attitudes and information and context. Relative to the younger and newly qualified radiographers it is apparent that they are better informed about HIV/AIDS than other categories of contagion.

5. The treatment of known AIDS cases is apparently different to others, with less touching and communication and something needs to be done to change professional behaviour. In education it would be advisable to implement more work in the area of interpersonal skills and communication. This focus needs to start at the basic level because not enough time is being devoted to the psychology of patients. Students struggle with the concept of dealing with sick people.

6. In addition, an integrated multi disciplinary approach to education in the area would be beneficial (Doctors, Nurses and others) so that human values education can be appreciated together on a team basis.

7. Universal Precautions is the framework for education efforts and the affective material is included in the framework, not separately. AIDS patients are no different from other patients except by nature of the virus.

8. Noting that neophytes' basic knowledge base is okay and that they are socialised by poor role modelling by long term employees who need to be resocialised through in-service education.

Focused Discussion: Physiotherapy and HIV/AIDS

1. The main point of the focused discussions was that the physiotherapists as a general rule, are concerned with treating symptoms related to the ability and independence of movement for patients rather than getting involved in "the how, why and when" of the causes of HIV/AIDS.

2. Patients get treated with respect and compassion just like anyone else and physiotherapists are certainly prepared to express sympathetic concern but their main focus is in treating "what they find" with their specialised knowledge and skills in therapy - a goal and task orientation that differs from the work of nurses, counsellors and social workers whose knowledge of clients is based on larger term experience and a more holistic involvement. "Compassion without patronage" was emphasised.

3. It was acknowledged that physiotherapists, like other HCWs, need general awareness of the importance of Universal Precautions in HIV/AIDS patient care, which has to be used with tact and discretion according to the particular requirements of individual patients at different stages of the disease. Again the focus was on treatment for ambulatory movement (mobility and independence) within the capability of the patient. Not every AIDS patient was suitable for physiotherapy for much depends upon the stage of progress of the disease and the varied ways patients were affected. Essentially physiotherapists make their own judgements as to treatment after referral by doctors and nurses or other HCWs. In that sense physiotherapists regarded their role as a second line, supportive one working within a frame of reference mainly set by others (doctors, nurses in particular).

4. As for the tertiary education of physiotherapists, work was necessary on infection education generally, with special reference paid to HID/AIDS. Attention needed to be paid to :

   - allaying fears, prejudices and misconceptions so that physiotherapists could understand the HIV/AIDS condition and their personal reactions to it so that they are comfortable with the knowledge and their own role in relation to HIV/AIDS patient treatment

   - knowledge of and use of universal precautions as required so that ignorance did not get between patient care. Physiotherapists did not need to regard themselves as high risk HCW in the treatment of HIV/AIDS so knowledge of UP need only be of a wise and precautionary kind. A basic awareness of UP seems to be sufficient for precautions against the most obvious risks.

Focused Discussion: Catholic Diocese Community Care/HIV/AIDS Project

Background

This discussion emanated from an integrated viewpoint including Counselling, Social Work and Community interest.

Key points:

Education and Training in HIV/AIDS work for HCW needs to address these matters:

1. Prioritise HVE and interpersonal and communication skills expertise.

2. Have access to quality up to date information (not media oriented) with a social dimension as well as a health perspective.

3. In-house and ongoing education updates are required in the workplace.

4. A sequential and planned orientation to curriculum matters regarding HIV/AIDS works best.

5. Issues such as Universal Precautions and confidentiality are important.

6. People who do social work should network outside institutions for liaison and support and not take a "possessive" stance regarding the patient and the disease.

7. Volunteers as HCW are assigned to teams according to skills and expertise and willingness. A team approach to care works well.

8. There is a need to know about the virus, safety, precautions, contacts, networks, referrals, affective skills, facts, attitudes, grief.

9. Medical orientations need to add a social perspective to education and knowledge generation.

Focused Discussion: Aboriginal Health and HIV/AIDS (The Aboriginal Community Recreation and Health Service-ACHRS)

With regard to key health care personnel that the service deals with it became evident that aside from the clinic at the ACRHS, the AIDS Council was the main point of reference. Programs in place include NU-HIT (Nunga Users HIV Intervention Team) for metropolitan Aboriginal people, a needle exchange program, and YSTC (Youth Sector Training Council) for teaching about Safe Sex, Family Planning and other matters.

Through ACRHC a worker serves in an Advisory capacity eg with the SAHC Education and Health with regard to HIV/AIDS and Aboriginal people with the main focus of work related to Counselling seeking support for self as well as other community members. In addition, the idea is to build up a network for liaison, preventative health and education, and some referral work that mainly is directed to the Service's clinic, and sometimes the STD clinic. From the perspective of this discussion the community interest focus was defined as related to ("at risk" people). Apparently the centre (clinic) is easy to access, with no problems encountered. There were also no special comments regarding relationships to HCW. Confidentiality is of paramount importance and explains the "nothing to discuss" aspect here. Quote: "Eyes, ears and mouths shut" and this approach to relationships is respected hence no "bad" reports. The most difficult experiences at-risk people have with HCW more relates to the people themselves not being comfortable or trusting, to come and seek a "service".

Improvement noted: People now come to the service much more freely - they are not keen on accessing "public" service. Final Note - the service was perceived as working well, with good relations involving trust and confidence. More and more come to use it. A good model of practice. "A story in our hands to share" from the Darwin Project, adapted by the worker into the SA Model is a key teaching/learning tool used in HIV/AIDS education.

Other key points:

The key theme to emerge from the meeting was about the means of communication ideas and information about HIV/AIDS to Aboriginal people in relation to all kinds of health care workers. Essentially Aboriginal people prefer to communicate through stories rather than the usual (for formal education institutions) means of codified and tightly structured knowledge. This was graphically illustrated by referring to the traditional means of learning through walking and talking rather than sitting down to be handed knowledge in a classroom type context. This story line approach is being used as an HIV/AIDS education awareness program for Aboriginal people called. Related to HIV/AIDS communication for at risk people, it was stressed several times that Aboriginal people are aware of their marginal and de-powered position in the community, compounded by the experience of discrimination and racist attitudes, which makes them very distrustful of "white" institutions. Even with their own health care service Aboriginal people want their health conditions, beyond HIV/AIDS matters, to be kept confidential, especially if there is any chance of being labelled as gay and/or a drug user, making worse the everyday experience of stereotyping and marginality.

Focused Discussion: Counselling in HIV/AIDS

1. The primary emphasis was on the practical value of having a level of competence in the use of counselling skills in HIV/AIDS work with clients and other personal relations.

2. The initial focus was on counselling skills used in a pre and post test context and the need for relevant training in such skills as active listening, non-judgemental behaviour, empathy, personal respect to equalise power differentials in personal relations, and empowering clients to make choices.

3. Attention focused on how to incorporate counselling skills in a context where there is a high level of experiential learning arising from intensive

work in HIV/AIDS and other human relations involving sexuality and death matters, including other forms of STD. The main point was to help people work with their own life experiences and problem based material, sometimes inviting people to address their deep personal fears through case scenarios embodying real situations that touch upon personal values.

4. The emphasis of counselling skills should not be conceived as a model driven approach based on codified knowledge but rather move on 'real life' related principles and processes that lead to the situations described in 3. above

5. Counselling skills (CS) need to be programmed on a continuous learning basis rather than on a 'one-off' basis, and should be regarded as a form of human values education.

6. It was acknowledged that the problem with professional education in tertiary institutions is the emphasis on selection and control and the formal transmission of knowledge which sometimes makes it difficult to approach learning in a more adult and experiential way. There was also discussion on the ethos and dominant paradigm of professionalism with its emphasis on management and control of illness and disease, driven by the cure and fix approach, which tends to focus too much on the presenting symptom rather than the whole person and their social context.

7. It was advocated that HIV positive people should be deployed in counselling roles as part of the education and training of HCWs.

8. As a feature of any CS program for HCW in HIV/AIDS attention should be focused on allaying fears through good quality information to explain the transmission and stages of progression, awareness of risk factors and ways in which HIV may be acquired. HIV/AIDS should not be regarded as just "out there". It was important to demystify by explaining the facts. This provides the basis (see 2 and 3 above) for CS that enables people (HCWs) to examine their own values and behaviour, especially with regard to sexuality and death, so as to take down personal barriers and get in touch with personal emotions and vulnerability so as to meet one's own fears, name them and look more closely at personal relationships.

Other points:

At the moment there are approximately 85 percent gay males, 12 percent occurrences including heterosexual and accidental infections and 3 percent women and children in the HIV/AIDS infected population in Australia.

The key aspects of working with this clientele revolves around values The need to know about these values particularly clarification and confrontation is essential for Health Care Workers. This facilitates non-homophobic behaviours as well as an awareness of heterocentrism. Should this not be the case regarding the nature of the HCW the focus of care is more on the nature of who is consulted eg. medic or dentist, rather than the person affected by the virus. They (the HCW) miss the "whole picture".

It is important for the medic etc to approach the problems in a broad way so that the ignorance and arrogance of the narrow scientific view can be avoided and the HCW can be informed and articulate regarding care both personal and specific. This is particularly important when considering the context of people affected by the virus as such marginalised groups present a better and more articulate critique of society.

More points:

1. HCW need to be comfortable and clear about sexuality and associated issues.

2. Teaching methods for education in sexuality issues could include gay men as the facilitators of learning. Other representatives of marginal groups could be employed also.

3. Emphasis in the HCW course needs to be in its philosophy reflecting an appropriate paradigm such as Positive Living models for education rather than traditional ones where the "ill" are seen as "victims", eg people living with HIV/AIDS and the effects of positive attitudes and positive effects of living on the immune system.

Focused Discussion: Intravenous Drug User and HIV/AIDS

Background:

This person interviewed is HIV Positive and currently on a Methadone Program to treat his drug addiction problems. He has been on the program now for three and a half years.

A few years ago he inadvertently used his brother's needle to inject heroin for a fix. His brother was later confirmed HIV Positive. It was not until sometime later that it became apparent that he had also been infected by the virus. His nineteen year old fiance was at this time also injecting drugs and at the time of his diagnosis was coping with the death of her grandfather with whom she was very close. She had also been infected with the virus and had tested positive, and had to be told. Both apparently had no pre or post testing counselling and it came as a "bolt out of the blue" particularly to the youth in this story as he was the first to be told the results. This history was the culmination of injecting drug use with inadvertent sharing of needles and a story which included living in "The Cross" for a while selling drugs to support the habit and fleeing interstate to safe quarters to commence a Methadone program to cope with withdrawal and illness resulting from no access to Heroin. A fortnight in prison for a fine was part of the experience of this person. Anecdotal evidence of prison inmates using intravenous drugs and the needle exchange requirements was presented. HIV Positive people were allowed methadone as necessary to control behaviour because the risk of withdrawal symptoms and the subsequent possibility of sharing a contaminated needle was too great. The youth is still on a high methadone requirement while his fiance is reducing her need more rapidly.

Another aspect of his story worth telling was the ostracism from family. An example was demonstrated by his sister, a "clean freak" who pretended to wash the coffee cups after a visit and instead was seen "throwing them out in the garbage".

Key points:

1. Education programs including needle exchange are important for harm minimisation.

2. Pre and post test counselling should be mandatory.

3. HVE is an essential part of HCW approach to caring for HIV Positive people.

4. People in detention need the same care/education as those who are not and require extra vigilance in harm minimisation efforts because of the risks posed by lifestyle and living proximity.

5. Family counselling and support programs may help people deal with fears and myths.

Focused Discussion: Gay Rights Group

The two respondents were of the opinion that whereas the Gay Rights Group were well versed in general advocacy about the needs of their members, they had not made a special study of HIV/AIDS in the SA gay community. Nonetheless the content of the subsequent discussion was certainly well observed and based on reliable evidence drawn from experience.

HIV and gay people mostly had dealings with doctors, both general practitioners and specialists, working from STD clinics. Either way, gay people needed to relate to doctors on the basis of trust. They also expected doctors to show understanding of the context and quality of gay lifestyles, but it was not necessary to be a gay medic. Generally speaking the problem of relationships was more about a lack of knowledge of HIV/AIDS as experienced by positive gay people, than active prejudice and discrimination, although it was apparent that some doctors with particular religions and cultural beliefs did seem to have problems coping with gay sexuality. Even more generally, many doctors had difficulty managing to keep their 'heterosexual centrism' off the agenda of the consultation process.

Ideally, gay people, in the context of HIV/AIDS, wanted doctors in particular, but possibly HCWs in general, to modify their 'world view' about human sexuality and the quality of their relationships with people of different sexual habits and preferences. This view was regarded as very idealistic, even simplistic, but it expressed an important principle underpinning the nature of relationships, of at least striving to achieve a non-judgemental and sympathetic involvement, without prejudice.

In more basic terms, gay HIV positive people would prefer doctors (and HCWs generally) to remove gender bias in their questions to clients/patients and simply ask different ones which did not operate from conventional assumptions

about sexual preferences and lifestyles, putting gay people on the defensive. An example of a right question to ask would be "Are you sexually active"?

Attitudes: In terms of the desirable attitude for HCW, they should be comfortable enough to allow gay people to freely express themselves about sexual health and related matters, in an affirming, non-judgemental way. Too often it was observed that there was a link between negative attitudes and wrong assumptions about gay people and their sexuality.

Knowledge: As for the knowledge requirements, HCW needed to use universal precautions systematically and understand why it was necessary. They also needed the facts about the transmission of HIV.

Skills: With regard to skills, more basic counselling techniques are required based on a sound working knowledge of HIV/AIDS, especially in a pre and post test context. Active listening skills are useful along with a willingness to learn from experience and the insights of patients/clients by having a basic curiosity and liking for people, mediated through a good questioning ability.

Other points: The view from HIV positive people in the gay community is that HCW not only represented the colonising tendencies of the medical and science professions, but also the conservatism of mainline social attitudes in the wider community, and consciously or otherwise, were too concerned to 'fit people into their model and world view', rather than adopt a more realistic value position.

Focused Discussion: Sex Industry HIV Support Worker

In response to question1, the respondent stated that access to HCWs would depend on the kind of work undertaken by sex workers (with men or women or bi-sexually) and their particular personal health needs, not just confined to HIV matters. Typically though, doctors, social workers and counsellors were those most often contacted by sex workers, either directly or through the guidance of the HIV support worker according to need.

With regard to best experiences and practices, those HCWs who could relate genuinely to clients in a non-judgemental way, and were able to treat their needs in a developmental way, that is, not just be content to prescribe pills and behaviours, but to get to know and understand the person and their lifestyle choices, above all, to provide help and support on the basis of mutually agreed needs of clients/patients, was an ideal of best practice.

The opposite, most difficult experiences, as reported by the respondent, speaking on behalf of his network of contacts, was when HCWs treated sex workers as 'slut trash' and generally regarding them from a homophobic standpoint, expressing attitudes of non-acceptance and implicit assumptions that belied a discriminatory approach.

As for the things HIV positive sex workers hoped not to experience at the hands of HCWs was ostracisation and breaches of confidentiality (which was known to occur).

Thus a non-judgemental approach is the preferred attitude required from HCWs along with knowledge of the risks of infection and how HIV is transmitted. As for skills, HCWs should be capable of relating and communicating to clients/patients without talking down to them or over their heads.

Background paper 3: Summary of the Initial Survey of Current Tertiary Education Programs for Health Care Workers in HIV/AIDS

Data Collection

The tertiary institutions targeted for the collection of curricula included the three South Australian Universities and the TAFE sector. We were aware of some patchiness in the response to our written and telephone follow up requests. Certificate, undergraduate, graduate and post-graduate courses were identified as being likely to contain a HIV/AIDS component. These health care disciplines were identified during the DACUM process conducted in the early stages of the project.

The following is a list of tertiary courses from both the TAFE and University sectors from which curriculum documentation was requested. Course or year level coordinators were identified and contacted with a written request for documentation.

Undergraduate Programs

Bachelor of Applied Science (physiotherapy)
Bachelor of Applied Science (medical radiations)
Bachelor of Nursing (post-registration)
Bachelor of Pharmacy
Bachelor of Dental Surgery
Bachelor of Dental Therapy
Bachelors of Medicine and Surgery
Bachelor of Health Science
Bachelor of Arts (psychology)
Bachelor of Social Sciences Human Services (social health)
Bachelor of Social Work

Graduate Programs

Graduate Diploma in Medical Laboratory Radiations
Graduate Diploma in Nursing
Graduate Diploma in Physiotherapy
Graduate Diploma in Social Science in Rehabilitation
Graduate Diploma in Clinical Pharmacy
Graduate Diploma in Psychotherapy
Graduate Diploma in Occupational Health
Graduate Diploma in Social Science (psych. practice)

Postgraduate Programs

Master of Public Health
Master of Nursing
Master of Science (primary health care)
Master of Psychology (clinical)
Master of Applied Science (physiotherapy)

Master of Health Science (occupational therapy)
Master of Nursing (advanced practice)

Other Programs

Introductory certificate in Community Services
Certificate in Primary Health Care
Associate Diploma in Dental Hygiene
Certificate in Community Services (care assistant)

Out of a total of thirty requests for documentation only a small number sent the information requested. The reason for this appeared to be best expressed by the Head of Department of Community Medicine at the University of Adelaide who stated that in the undergraduate and post-graduate courses in medicine in his department there are no courses or units specifically devoted to HIV/AIDS. However, the condition is widely used to illustrate important public health issues, such as screening, health education, social causes of illness and resource allocation. A number of similar responses were received from coordinators of nursing, social work, physiotherapy and social health programs.

In the Graduate Diploma of Social Science in Rehabilitation HIV does not feature in a specific way. However the course does address HIV in various areas—from sociological, medical and ethical perspective's.

In the Master of Science Palliative Care Stream HIV features specifically in a subject entitled 'The Practice of Palliative Care'. In this unit of work the student explores the major expressions of the HIV disease process and the natural history of AIDS. The students examines the unique psychological, social and physical impact AIDS has on patients, families and the community, and their impact on the process of dying. Finally the student looks at relevant interventions for both medical and other personnel in the palliative care of patients with AIDS. In the subject 'Oncology in Palliative Care' there is a unit 'Management of pain not due to cancer'. The function of this unit is to assist students in recognising and treating common pain symptoms which occur in hospice patients who do not have cancer or whose pain is not due to cancer. AIDS, Motor Neurone Disease and Venous occlusion and lymphoedema are included in this unit.

Of the documentation received Flinders University appeared to be the only provider that had a course devoted specifically to HIV/AIDS. As part of its third year medicine course the university has a three week course entitled 'HIV medicine'. The three week course is run by the Department of Microbiology and

Infectious Diseases and covers a range of topics from HIV/AIDS clinical features to the psychosocial aspects of HIV.

One of the features of this course is a two hour group discussion with people living with AIDS and talking about their experiences. This is held at the end of the three week course.

Perhaps the most significant course relating to the intentions of the research project is an optional program for registered nurses undertaking the Batchelor of Nursing run by the School of Nursing. The program provides for registered nurses in a variety of work settings with skills and knowledge designed to ensure competent, empathetic and comprehensive care to people with HIV/AIDS. The program spans a semester based on a weekly 4 hour session and uses a variety of teaching methods, including small group work, role play, video and discussion to foster active participation and learning as well as an acknowledgement of "difference" in this highly emotive area of human relationships. Upon completion students are expected to demonstrate a range of counselling strategies in a variety of clinical settings; provide a broad range of educational programs suitable for people who are HIV positive, including their carers, family members, friends, community members and health care workers; and act as an advocate for people with HIV to ensure the principles of social justice are fully realised.

Background paper 4: The Matrix Model used to group and classify data from the focused discussions

(selected examples only)

LEARNERS and PROGRAMS	Affective domain	General knowledge domain	Specialised skills domain
New learners a. Neophyte b. Experienced workers but new to the field	. Values clarification regarding sexuality, drug use and death. . Being non-judgemental and non-discriminatory in relating to patients. . Understanding grief and loss. . Questioning sterotypes and media images.	. Transmission of the virus - epidemiology . Myths and misconceptions. . The disease process and the use of universal precautions. . Psycho-social aspects i.e. women and HIV . Legal frameworks and ethical issues.	. Basic counselling skills to relate to patients openly and helpfully. . Pre/post test counselling. . Specific nursing procedures. . Safe sex practices/needle exchange.
Updating learners Familiar with HIV/AIDS work but needing to know more	. Continue to review and update personal values clarification. . More advanced understanding of grief and loss combined with updated counselling skills.	. The disease process in more detail. . Drug treatments in HIV/AIDS process. . Substance use and HIV. . Specific aspects of nursing care. . Nutritional aspects.	Continuing the above specialised interests into different aspects of HIV/AIDS continued i.e. Aboriginal people, women etc.
Undergraduate level	As for new learners.	. As for new learners, plus national policies on HIV/AIDS and the quality/relevance of tertiary programs.	As above for new learners.
Postgraduate level	As for updating learners.	. As above, but continuing the level and range of knowledge applicable to each topic area.	As above updating learners and also - teaching skills - advanced counselling skills - advocacy skills
In-house and/or in-service	All of the above	As above	As above
Pre-service and/or non-award	Introductory to all of the above.	As above	As above

LEARNERS and PROGRAMS	Affective domain	General knowledge domain	Specialised skills domain
New learners a. Neophyte b. Experienced workers but new to the field	New learners need to be socialised in relation to HIV/AIDS. This can best be achieved through experiential learning with a theoretical underpinning. New learners may have to confront and accept issues/behaviours that are not necessarily congruent with their own belief systems and/or experience regarding such issues as sexuality, homosexuality, IVD user etc.	Terminology - Virology - Immunology - HIV/AIDS - Immunity - Antiretrovirus Drugs - Political aspects of funding and policy making in the health field. - Cultural aspects	Strong philosophical and nursing theoretical base - what is their role? Communication skills
Updating learners Familiar with HIV/AIDS work but needing to know more	Learning how to respond to the media. How to discuss HIV/AIDS related issues with family/friends etc. Coping with conflict and disagreements on a personal level.	- Epidemiology - Transmission - IVD - Sex - Local, national and international perspectives - Legal implications - confidentiality - equal opportunity - discrimination	- Knowing what resources are available /access them. - Safe practices with regard to occupational exposure - Dealing with family dynamics
Undergraduate level	Issues dealing with control/partnership. The client must be allowed control. Allowance must be made for client assertiveness and communication on their terms.	- Testing and notification - Treatments - clinical presentations and pharmacology	Knowledge of official policies - ANF -Institutional - Pre and post test councelling - Classification of HIV - Ability to conduct a patient assessment including ascertaining patients support systems, resources available to them etc. - Clinical & psychosocial assessment.
Postgraduate level	Advocacy to colleagues. Advocacy to clients. Coping with stress.		Representation on policy making groups/ committees. - Knowledge of how the health care system works - policies etc. - Counselling skills.
In-house and/or in-service	How to form an opinion and then put it into a professional framework in terms of the socio-political issues.	Loss and grief - relationships - self - social How to network with HCWs in the field.	Knowledge of policy issues related to: - refusal of care - HIV positive HCWs - legal issues - professional issues - ethnical issues How to pre and post test counsel clients.
Pre-service and/or non-award			How to educate peers.